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worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional;

(iii) A professional certified as either a Clinical Supervisor by the Substance Abuse Certification Alliance of Virginia or as a Master Addiction Counselor by the National Association of Alcoholism and Drug Abuse Counselors.

(3) Residential facility capacity shall be limited to 16 adults. Dependent children who accompany the woman into the residential treatment facility and neonates born while the woman is in treatment shall not be included in the 16 bed capacity count. These children shall not receive any treatment for substance abuse or psychiatric disorders from the facility.

(4) The minimum ratio of clinical staff to women should assure that sufficient numbers of staff are available to adequately address the needs of the women in the program.

2. Substance abuse day treatment services for pregnant and postpartum women. This subdivision provides for required services which must be provided to women, linkages to other programs tailored to specific needs, and program and staff qualifications. The following services must be rendered and documented in case files in order for this day treatment service to be reimbursed by Medicaid:

a. Services must be authorized following a face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed professionals as specified in 12 VAC 30-130-540 through 12 VAC 30-130-590.

(1) To assess whether or not the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level II.1 (Intensive Outpatient Treatment) or Level II.5 (Partial Hospitalization) as described in *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition*, as amended, published by the American Society of Addiction Medicine. Services shall be reauthorized every 90 days by one of these appropriately authorized professionals, based on documented assessment using Level II.1 (Adult Continued

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Service Criteria for Intensive Outpatient Treatment) or Level II.5 (Adult Continued Service Criteria for Partial Hospitalization Treatment) as described in *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition*, as amended, published by the American Society of Addiction Medicine. In addition, services shall be reauthorized by one of the appropriately authorized professionals if the patient is absent for five consecutively scheduled days of services without staff permission. All of the authorized professionals shall demonstrate competency in the use of these criteria. This individual shall not be the same individual providing nonmedical clinical supervision in the program.

(2) Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate re-authorizations after absences.

(3) Documented assessment regarding the woman's need for the intense level of services; the assessment must have occurred within 30 days prior to admission.

(4) The Individual Service Plan (ISP) shall be developed within 14 days of admission and an obstetric assessment completed and documented within a 30 day period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

(5) The ISP shall be reviewed and updated every four weeks.

(6) Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

(7) Face-to-face therapeutic contact with the woman which is directly related to her ISP shall be documented at least once per week.

(8) Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning must begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports.

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(9) While participating in this substance abuse day treatment, the only other mental health, mental retardation or substance abuse rehabilitation services which can be concurrently reimbursed shall be mental health emergency services or mental health crisis stabilization services.

b. Linkages to other services or programs. Access to the following services shall be provided and documented in the woman's record or program documentation.

(1) The program must have a contractual relationship with an obstetrician/gynecologist. The obstetrician/gynecologist must be licensed by the Virginia BOM of DHP as a medical doctor. The contract must include provisions for medical supervision of the nurse casemanager.

(2) The program must have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24 hour access to services for the women and ongoing training and consultation to the staff of the program.

(3) In addition, the program must provide access to the following services (either by staff in the day treatment program or through contract):

(a) Psychiatric assessments, which must be performed by a physician licensed to practice by the BOM of Virginia DHP.

(b) Psychological assessments, as needed which must be performed by clinical psychologist licensed to practice by the BOP of Virginia DHP.

(c) Medication management, as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the BOM of Virginia DHP, in consultation with the high-risk pregnancy unit, if appropriate.

(d) Psychological treatment, as appropriate, for present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the BOP of Virginia

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(e) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., Medallion or other Medicaid sponsored primary health care program).

c. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

(1) The provider of treatment services shall be licensed by the DMHMRSAS to provide either Substance Abuse Outpatient Services or Substance Abuse Day Treatment Services.

(2) Nonmedical clinical supervision must be provided to staff at least weekly by one of the following professionals:

(i) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a Substance Abuse Counselor by the Board of Professional Counselors, Marriage & Family Therapists (BPCMFT) of the Virginia DHP or as a Certified Addictions Counselor by the Substance Abuse Certification Alliance of Virginia or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors;

(ii) A professional licensed by the appropriate board of Virginia DHP as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addition counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as licensed substance abuse professional;

(iii) A professional certified as either Clinical Supervisor by the Substance Abuse Certification Alliance of Virginia or as a Master Addiction Counselor by the National Association of Alcoholism and Drug Abuse Counselors.

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(3) The minimum ratio of clinical staff to women should assure that adequate staff are available to address the needs of the women in the program.

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Q. General Outpatient Physical Rehabilitation Services

1. Scope

A. Medicaid covers general outpatient physical rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals and by rehabilitation agencies which have a provider agreement with the Department of Medical Assistance Services (DMAS).

B. Outpatient rehabilitative services shall be prescribed by a physician and be part of a written plan of care.

C. Outpatient rehabilitative services shall be provided in accordance with guidelines found in the Virginia Medicaid Rehabilitation Manual, with the exception of such services provided in school divisions which shall be provided in accordance with guidelines found in the Virginia Medicaid School Division Manual. Utilization review shall include determinations that providers meet all the requirements of Virginia State regulations found at VR 460-04-3.1300. Utilization review shall be performed to ensure that services are appropriately provided and that services provided to Medicaid recipients are medically necessary and appropriate.

2. Covered Outpatient Rehabilitative Services.

A. Covered outpatient rehabilitative services for acute conditions shall include physical therapy, occupational therapy, and speech-language pathology services. Any one of these services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service. Such services may be provided by outpatient settings of hospitals, rehabilitation agencies, and home health agencies.

B. Covered outpatient rehabilitative services for long-term, chronic conditions shall include physical therapy, occupational therapy, and speech-language pathology services. Any one of these services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service. Such services may be provided by outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, and school divisions.

3. Eligibility Criteria for Outpatient Rehabilitative Services. To be eligible for general outpatient rehabilitative services, the patient must require at least one of the following services: physical therapy, occupational therapy, and speech-language pathology services. All rehabilitative services must be prescribed by a physician.

4. Criteria for the Provision of Outpatient Rehabilitative Services. All practitioners and providers of services shall be required to meet State and Federal licensing and/or certification requirements. Services not specifically documented in patient's medical record as having been rendered shall be deemed not to have been rendered, and no coverage shall be provided.

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Q. General Outpatient Physical Rehabilitation Services

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B. Outpatient rehabilitative services shall be prescribed by a physician and be part of a written plan of care.

2. Covered Outpatient Rehabilitative Services. Covered outpatient rehabilitative services shall include physical therapy, occupational therapy, and speech-language pathology services. Any one of these services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service.

3. Eligibility Criteria for Outpatient Rehabilitative Services. To be eligible for general outpatient rehabilitative services, the patient must require at least one of the following services: physical therapy, occupational therapy, and speech-language pathology services. All rehabilitative services must be prescribed by a physician.

4. Criteria for the Provision of Outpatient Rehabilitative Services. All practitioners and providers of services shall be required to meet State and Federal licensing and/or certification requirements.

A. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

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2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

B. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist as defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

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3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that amount, frequency, and duration of the services shall be reasonable.

C. Speech-language therapy services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

5. Authorization for Services

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, home health agencies, or school divisions shall include authorization for up to twenty-four (24) visits (without authorization) by each ordered rehabilitative service annually. The provider shall maintain documentation to justify the need for services. A visit shall be defined as the duration of time that a rehabilitative therapist is with a client to provide services prescribed by the physician. Visits shall not be defined in measurements or increments of time.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized. Documentation for medical justification must include physician orders or a plan of care signed by the physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS. Periods of care beyond those allowed which have not been authorized by DMAS shall not be approved for payment.

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6. Documentation Requirements.

A. Documentation of general outpatient rehabilitative services provided by a hospital-based outpatient setting, home health agency, school division, or a rehabilitation agency shall, at a minimum:

1. describe the clinical signs and symptoms of the patient's condition;

2. include an accurate and complete chronological picture of the patient's clinical course and treatments;

3. document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;

4. include a copy of the physician's orders and plan of care;

5. include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);

6. describe changes in each patient's condition and response to the rehabilitative treatment plan; and

7. describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

7. Service Limitations. The following general conditions shall apply to reimbursable physical rehabilitative services:

A. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.